Neutral Citation Number: [2020] EWHC 1470 (Admin)

Case No: CO-817-2020

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 07/07/2020

Before:

MR JUSTICE MOSTYN

- -

Between :

The Queen on the application of
JP
(by his father and litigation friend BP)

Claimant

- and -

NHS CROYDON CLINICAL COMMISSIONING GROUP

1ST Defendant

- and –

THE LONDON BOROUGH OF CROYDON

2nd Defendant

- -
- -

Michael Armitage & Ciar McAndrew
(instructed by **Hopkin Murray Beskine**) for the **Claimant**
David Lawson (instructed by **Capsticks Solicitors LLP**) for the **1st Defendant**
Christine Cooper (instructed by **LB of Croydon Legal Services**) for the **2nd Defendant**

Hearing dates: 23-24 June 2020
The hearing was conducted remotely by Zoom

- -

Approved Judgment

Mr Justice Mostyn:

1. For the reasons given below, the decisions made by the first defendant on 27 November 2019, 19 December 2019 and 14 January 2020 are set aside. The claimant, JP, will be promptly reassessed by a fresh panel and a fresh nurse assessor will be appointed. The order for interim relief will remain in force until the reassessment has been concluded. The other claims against the first and second defendant will be dismissed.

2. JP is seven years old. In September 2017, just after he had started primary school, he was diagnosed with a malignant brain stem tumour. Surgery removed most, but not all, of the tumour. He spent several months in hospital, some of which in a vegetative state. In May 2018 he was well enough to be discharged from hospital. However, the failure to achieve a complete surgical excision of the tumour means that he suffers from a range of serious health issues including, in particular, respiratory problems. In order to meet those problems JP has been fitted with a tracheostomy and is supported by mechanical ventilation during his night-time sleeping hours.

3. In May 2018, shortly after he was discharged from hospital, the first defendant ("the CCG") assessed JP as eligible for continuing care and commissioned provision to him of 63 hours per week of night-time care (i.e. nine hours each night) and 45 hours per week of daytime care during the school term. The daytime carer would accompany JP on his journey to and from school and would care for him whilst he was at school.

4. In August 2018 that care provision was confirmed following a further assessment.

5. In October 2019 the CCG initiated a reassessment of JP's care provision. This led, in circumstances which I will set out in greater detail below, to a decision by the CCG on 27 November 2019 that JP was no longer eligible for continuing care and to reduce the scale of weekly care to four nine-hour nights in term time, and five nine-hour nights in holiday time. Further, the daytime care in term time was reduced to remove cover for JP's journey to and from school. That decision was confirmed on 19 December 2019 and an appeal was dismissed on 14 January 2020. However, shortly after the issue on 27 February 2020 of judicial review proceedings impugning these decisions, the second defendant ("the local authority") agreed to put in place transport arrangements which ensured that one of JPs parents would be able to accompany him to and from school. So that latter issue has fallen away.

6. The focus of the dispute before me has therefore been largely confined to the reduction in the night-time care of JP.

7. There are six issues I have to decide:

    i) Was the CCG's decision that JP was no longer eligible for continuing care, and that his package of support should be reduced, irrational?

    ii) Did the CCG provide adequate reasons for its decision?

    iii) Did the CCG fail to comply with the relevant procedure set out in the national framework for NHS continuing care assessments?

iv) Did the CCG misapply the national framework when reaching its substantive decision on JP's eligibility for continuing care?

v) Has the local authority approached its assessment of JP's care needs in a lawful manner?

vi) Have the CCG and the local authority unlawfully failed to cooperate with one another?

8. Although I have been referred to a very substantial number of authorities (the three authorities bundles contain 1679 pages), there is no serious dispute about the law. In cases such as this I always remind myself of the classic formulation by Lord Greene MR in *Associated Provincial Picture Houses Ltd v Wednesbury Corporation* [1948] 1 KB 223, CA. Although there have been hundreds of decisions since then its fundamental tenets remain untouched.

9. The principles are:

i) Judicial review of an exercise of executive power is a remedy of last resort. It will not be granted if there exists an equivalently efficacious alternative remedy.

ii) The judicial review court is not a court of appeal. In a court of appeal the challenge may either be to the decision-making process or to the outcome. In the judicial review court challenges are almost inevitably to the decision-making process; challenges to outcome are exceedingly difficult.

iii) A person exercising an executive power must:

a) not act dishonestly or in bad faith or in breach of a person's Convention rights;

b) direct himself properly in law and properly apply it;

c) call his own attention to the matters which he is bound to consider by asking himself the right question and taking reasonable steps to acquaint himself with the relevant information to enable him to answer it correctly;

d) exclude from his consideration matters which are factually incorrect or otherwise irrelevant to what he has to consider; and

e) give sufficient reasons for his decision so that any person affected can know why he has won or lost, and any judicial review court can conduct a meaningful review.

The natural justice principle of *nemo iudex in causa sua* is captured by the requirement of acting in good faith. The principle of *audi alteram partem* is caught by the requirement of calling attention to the matters the decision-maker is bound to consider.

iv) Provided that these rules are followed, the decision itself will be almost immune from challenge. Where the rules are followed, a challenge to outcome will only

be possible where it can be said that the decision is so absurd that no sensible person could ever dream that it lay within the powers of the decision-maker.

10. I now examine the context in which the impugned decisions were made. They were governed by a document issued by the Department of Health called the National Framework for Children and Young Persons Continuing Care 2016. Unlike the regime for adults this scheme is not prescribed by any statute or statutory instrument. The Framework is well described in Mr Armitage's skeleton argument from which I quote as follows:

> "The Framework sets out guidance for CCGs when assessing the needs of children and young people whose complex needs cannot be met by universal or specialist health services. As well as describing, in detail, the process to be followed when carrying out such assessments (and making subsequent decisions on the nature and extent of any care to be provided), the Framework includes a decision-making tool (the "DST") to be used to assist in assessing children's needs across 10 "domains" (covering areas such as breathing, eating and drinking and mobility). The DST sub-divides each domain into ascending "levels of need", namely "no additional needs", "low", "moderate", "high", "severe" and "priority", with descriptions given of the matters corresponding to each level of need in each domain. The Framework states that a child is "likely to have continuing care needs if assessed as having a severe or priority level of need in at least one domain of care, or a high level of need in three domains of care": see para 148. However, the Framework makes clear that this is not a firm rule, and that assessors, when presenting recommendations to the decision-making forum, should "consider the level of need identified in all care domains in order to gain the overall picture": para 149.
>
> In relation to the "breathing" domain, which is of particular importance in the present case, the Framework indicates (see pp. 32 – 33) that a child's needs will be "severe" if the child:
>
> > 'Has frequent, hard-to-predict apnoea (not related to seizures); **or** severe, life-threatening breathing difficulties, which require essential oral pharyngeal and/or nasopharyngeal suction, day or night; **or** a tracheostomy tube that requires frequent essential interventions (additional to routine care) by a fully trained carer, to maintain an airway; **or** requires ventilation at night for very poor respiratory function; has respiratory drive and would survive accidental disconnection, but would be unwell and may require hospital support.'"

11. If a child scores one severe mark or three high marks he or she will be designated as "eligible" for continuing care. But such a designation does not answer the question of how much continuing care. Conversely, a failure to score one severe mark or three high marks does not shut out a child from all care, continuing or otherwise. On 27 November 2019 JP scored only one high mark. Consequently, he was designated as not "eligible" for continuing care, yet he was commissioned night-time care that was 4/7ths (term-time) or 5/7ths (holiday-time) of what had gone before. The scale of this non-eligible, non-continuing, care was informed by the use of another tool called the CCHAT which, counterintuitively, stands for Continuing Care Health Assessment Tool.

12. Mr Lawson forcefully and eloquently argued that the level of non-eligible, non-continuing care is unconnected to the result generated by the DST. I cannot accept this argument. It is obvious to me that had the result generated one severe mark or three high marks, the night-time care provided to JP would not have been altered. It is true that the scale of the departure from the previous night-time care was not explicitly determined by the result generated by the DST. But the decision whether to depart from the previous night-time care regime was, in my judgment, influenced critically by the result generated by the DST. The quantum of departure is more discretionary. In making that decision the DST and CCHAT results are clearly relevant factors.

13. Therefore, JP rightly focuses on the process which led to the DST score.

14. In May and August 2018 JP was assessed by Rebecca Kelfa-Caulker, a Children's Continuing Care Nurse Assessor. On each occasion she recorded a severe mark in the breathing domain. In the August 2018 assessment she wrote:

> "JP cannot effectively breathe independently because of poor respiratory drive following surgery for excision of a brain tumour this has also resulted in him experiencing breathlessness and an inability to cope with his respiratory need without a tracheotomy and supportive ventilation at night. JP is not on inhalers but he is on nebulised 6% sodium chloride (NaCl) twice daily and that can increase if his secretion is too think and he becomes too difficult to suction. JP has a tracheostomy because of 4 failed attempts at extubating as an inpatient because of the reasons listed above. Due to chemotherapy treatment he is immuno-compromised leading to greater risk of chest infection. JP requires regular suctioning (both mouth and tracheostomy due to unsafe swallow and lack of a cough reflex) to manage his secretions and he is on regular nebulisers of NaCl .His tracheostomy will need to be changed monthly unless it falls out by accident in which case it needs to be replaced. His tracheostomy tapes and dressing needs changing once daily. An Emergency Respiratory Care Plan is in place and must be followed in an Emergency. JP has had one aspiration episode since discharge. He had oral antibiotic and required a hospital visit. JP physiotherapy is associated with his mobility and not respiration. JP has carers at night to keep him safe and ensure his airway is patent at

> night. He can require suction between 10- 15times at night depending on his respiratory status.
>
> His parents say that his tracheostomy is very stable and requires suctioning between 4 - 8 times a days.
>
> SEVERE Need Agreed"

15. The recommendation of the assessor is subject to independent ratification by a panel convened by the CCG. The assessor is not a member of the panel or a decision-maker but presents her recommendation to the panel. I have not seen the panel decisions of May or August 2018 but there is no dispute that the recommendation of the assessor on each occasion was ratified and implemented.

16. In October 2019 the appointed assessor was Diane Miles, a lead nurse for children and young people's continuing care and learning. She had the benefit of the opinion of Alexandra McClements, a paediatric long-term ventilation nurse specialist at St George's Hospital.

17. At that time JP was undergoing a trial to see if he could manage without ventilation overnight. This study had been undertaken on 11 September 2019. In order to do that study he must have been off the ventilator for a period. It would appear that another sleep study was undertaken in October with a period off the ventilator. That study suggested that he was breathing within acceptable standards off the ventilator, and that this could be made permanent subject to a review. It would appear that after completion of that study he was returned to the use of the ventilator at night until about 14 November 2019 when again he was taken off the ventilator. This led to another cardiorespiratory sleep study on 28 November 2019 which showed a persistent and increased number of apnoeas and hypopnoeas. Therefore, the overnight ventilation was reinstated with a plan to attempt non-invasive ventilation with potential decannulation from the tracheostomy in the spring of 2020. Unfortunately, that plan has been completely derailed by the coronavirus crisis.

18. It is important, therefore, to understand the factual context in which the impugned decisions were made. JP could not breathe unaided. He needed the use of a tracheostomy. Additionally, at night his apnoeas were managed with the use of the ventilator, although an experiment was being undertaken to see if he could manage without one.

19. On 29 October 2019 Ms Miles emailed Ms McClements enclosing the section of the DST that related to the domain of breathing and asking her to score him in that domain. She specifically asked Ms McClements to share sleep studies, clinical reviews and a summary of his airway and ventilation care plan.

20. On the same day Ms McClements replied, stating:

> "We have recently completed a sleep study off ventilation which is now within acceptable standards so we are planning on withdrawing ventilation on review. I can touch base with you once we have reviewed him in clinic and can update you with the plan and send over any

> information you may need. I would suggest that if we succeed with withdrawing the ventilation he would score a high under stable tracheostomy that can be managed by the child or young person or only requires minimal and predictable suction/care from a carer. Hope that information is helpful for now and I will be in touch after his appointment."

This email certainly does not suggest that JP was definitively and for the long-term capable of breathing at night without the aid of a ventilator. It is phrased in provisional and conditional terms.

21. The following day, 30 October 2019, Ms Miles completed her assessment. In the section about the domain of breathing she wrote:

> "Nurse assessor Conclusion:
>
> Health assessor has scored HIGH in this domain because evidence indicates that: JP has stable tracheostomy that can be managed by the child or young person or only requires minimal and predictable suction / care from a carer.
>
> Alexandra McClements Well Child Paediatric LTV CNS and the respiratory team at St Georges NHS trust scores HIGH; agreeing with the above.
>
> Agency report JP is copying very well with no ventilation overnight. Clinical notes confirm JP is self-ventilating overnight, no oxygen and sleeps well, requiring [suction] 1 -2 times a night but not every night."

22. I am afraid that this does not fairly or accurately reflect the opinion of Ms McClements. Ms Miles is representing Ms McClements as having said that the sleep studies demonstrated that JP could definitely manage long-term without the aid of night-time ventilation. She did not say that. Her opinion was heavily qualified, conditional and provisional, as I have explained above.

23. On 27 November 2019 the panel met to consider Ms Miles's assessment. The panel comprised Rachael Colley, the deputy director of continuing healthcare, PHB and neuro rehab at the CCG, and Dr Ide Ojo, a consultant paediatrician. In its summary of its assessment, as completed by the nurse assessor, it recorded under "breathing":

> "Breathing – scores HIGH
>
> JP has stable tracheostomy that can be managed by the child or young person or only requires minimal and predictable suction / care from a carer. Alexandra McClements Well Child Paediatric LTV CNS and the respiratory team at St Georges NHS trust scores HIGH; agreeing with the above.

> Agency report JP is coping very well with no ventilation overnight. Clinical notes confirm JP is self-ventilating overnight, no oxygen and sleeps well, requiring 1 -2 times a night but not every night.

24. Under "recommendation" it recorded:

> "In JP's case, as indicated in the DST domains of care, JP does not meet the eligibility criteria as he scores 1 x High in the breathing domain with no other triggers in any of the Domains for his health needs. However, the health assessor is recommending eligibility for health funding to the CCG. This is because JP has a tracheostomy in situ and requires regular intervention for airway clearance.
>
> CHATT 19
>
> However, 4 or 5 nights cover should be considered to ensure safe airway management."

25. I have to say that this is singularly unfortunate. The opinion of Ms McClements is completely misrepresented, and the decision is taken on the wholly false basis that the tests have established that JP was definitely able to manage long-term without the aid of a ventilator.

26. It is clear, therefore, that the panel made its decision by taking into account irrelevant and inaccurate information and also by failing to take into account accurate and relevant information that was available.

27. It is therefore a simple decision for me to make. The decision-making process was hopelessly flawed. Subject to the question of alternative remedy, to which I will turn, the decision cannot stand, and the exercise will have to be rerun.

28. It is a bitter irony that the day after this decision was made incorporating the view that JP could manage indefinitely without night-time ventilation, he was put back on night-time ventilation. And he has been on it ever since. Had that fact been known on 27 November 2019 it would have been improbable, in my judgment, that the panel would not have reiterated the marks of severe recorded in May and August 2018.

29. This fact was drawn to the attention of Ms Miles on 11 December 2019. On that day Ms McClements emailed Ms Miles stating:

> "We have recently completed a PSG on JP and sadly the results show that we need to restart his BiPAP again.
>
> I know that you were in the process of reviewing his care package, let me know if you need any further information. See the email below from Dr Chavasse. We will consider a transition to NIV in the new year with a decannulation if the oncology team agree."

Dr Chavasse is a consultant respiratory paediatrician responsible for JP's respiratory care.

30. On 12 December 2019 Ms Miles emailed Ms Colley stating:

> "In the meantime, yesterday evening I have received updated clinical info around a post ventilation stop sleep study. I have added this to the DST with my clinical views that this does not change the DST scoring from breathing. He is having central apnoeas however they are not unpredictable as they are occurring at night so I have added in is able to breathe unaided during the day but needs to go onto a ventilator for supportive ventilation. The ventilation can be discontinued for up to 24 hours without clinical harm."

31. On 18 December 2019 Ms McClements emailed Ms Miles stating:

> "We reviewed JP jointly with the oncologist, they were very happy with his progress and will continue to scan him 6 monthly to observe for any tumour regrowth. As you are aware, we recently conducted a full sleep study that has shown that JP was having significant central apnoeas, the oncologist explained that this would correlate with the MRI with some damage to the medulla. JP will therefore require ventilation until the foreseeable future. Our aim would be to remove the tracheostomy and deliver the ventilation via a non-invasive mask which will allow JP to have a better quality of life. We explained to the family yesterday that this is often a lengthy process and we would not start this process until the spring. We will meet the family in January and issue a mask for JP to get used too. We will also arrange a MLB procedure for the ENT team to review the tracheostomy and airway to ensure that it is safe for removal. We will then book him for a week inpatient stay to remove the tracheostomy and establish NIV. This is a process that is not always successful so if at any time JP would fail the tracheostomy would be reinserted.
>
> As JP's health needs have not changed since he was discharged. Dianne I understand that you are awaiting the DST review with the commissioners, will the package be reduced in the interim?"

32. This email was disclosed by Ms Miles to Ms Colley.

33. On 19 December 2019 Ms Colley wrote to JP's parents as follows:

> "Following the recent decision made at panel on Wednesday 27 November not to award Children's NHS Continuing Care. We were further updated following a sleep study by the LTV team at St. Georges Hospital. This updated information was added to

> the completed DST and was found not to change the original decision.
>
> - Not eligible for Children's NHS Continuing Care.
> - Health will fund 4 x 9 hour nights a week (term-time) and 5 x 9 hour nights (holiday time)
> - Term time carer will be provided 8:45 – 3:10
>
> Enclosed with this letter, you will find the appeals process and relevant forms to be completed should you wish to appeal this decision."

34. I have to say that there is a lot wrong with this process.

i) The news that JP was now back on night-time ventilator was a fundamental change of circumstances and basic fairness surely required that Ms Colley reconvened the panel. I do not accept Ms Colley's statement in her witness statement that there was no indication to bring the case back to the panel as there was not a significant change in score. Had the new evidence been properly represented and considered there could well have been a significant change in score.

ii) Ms Colley acting alone did not have the legal power to decide that the new information was not capable of altering the decision of 27 November 2019. That was a decision that only the full panel could take.

iii) The decision of 19 December 2019 failed properly to take into account highly relevant information. In particular, Ms McClement's important email of 18 December 2019 stating that JP's health needs "have not changed" since his discharge from hospital in May 2018 does not seem to have been taken properly into account.

iv) The decision took into account irrelevant and misleading information conveyed by Ms Miles to Ms Colley.

v) The decision was very inadequately reasoned.

35. Therefore, this decision will also, subject to the issue of alternative remedies, be set aside.

36. The parents duly mounted a "home-made" appeal. The CCG somehow got the idea that the parents were not quarrelling with the eligibility decision but rather with the consequential non-eligible non-continuing care plan. Of course, the parents were complaining about the composite decision which resulted in the significant reduction in overnight care. At all events, the appeal was summarily dismissed by Ms Colley on 14 January 2020 in the following terms:

> "I understand that you initiated an appeal in response to JP's Continuing Care assessment that was undertaken on 29 October 2019 (sic). Thank you for completing the appeals questionnaire

> and as a result of this I understand that Katherine Merritt (Children's Continuing Care Nurse Assessor) undertook an informal resolution meeting with you on Wednesday 8 January 2020.
>
> During this informal meeting, Katherine outlined the continuing care process and provided an explanation as to why JP does not meet eligibility for children's continuing care. I understand that you agreed with all the scoring in the domains and the conclusion was that you are not disputing the assessment but only want the care package to change back to pre-review hours.
>
> Because of this, I can advise you that your appeal is not upheld, as there is no grounds for appeal.
>
> As per our previous correspondence, the CCG does recognise that JP does have health needs and that is why we are going to be funding four nights 2200 - 0700 term time and 5 nights 2200- 0700 holiday time; with a carer being provided at school 0845 - 1515.
>
> If JP's health needs do change in the future and another referral is made to continuing care then we will respond accordingly. JP will be reviewed yearly with his next review being 27 November 2020."

37. As I understand it, there is an abstruse distinction drawn between a decision as to "eligibility", which does attract an appeal, and a consequential decision to award non-eligible non-continuing care, which does not. The latter decision is not appealable as such but can be challenged by a complaint under the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 (SI 2009 No. 309). Unsurprisingly, this distinction was not imagined by JP's parents.

38. The position of the CCG has been, and remains, that JP can appeal (again) against the eligibility decision and can mount a complaint against the consequential non-eligible non-continuing care plan. It says that this provides an equivalently efficacious alternative remedy to judicial review. However, the CCG doggedly refused to agree to reinstate the seven-night care pending determination of the appeal/complaint. The only way in which JP could achieve that reinstatement was by issuing these proceedings and seeking interim relief. This was in fact granted by Thornton J on 13 March 2020 when she granted permission. The CCG only changed its position and offered to keep the seven-night care cover in place pending determination of the appeal/complaint, following the award of interim relief. It did so in its detailed grounds of resistance on 26 April 2020.

39. It therefore seems to me that the CCG has in effect forced JP to litigate in these judicial review proceedings. It seems to me that it has made its bed in judicial review and must now lie in it. By the time that the CCG changed its position on 26 April 2020 a great deal of work had been done on this case. It is now "oven-ready" for a decision. It would be a waste of resources and involve a multiplicity of proceedings

for the case now to be stopped in order for this alternative path of appeal/complaint to be pursued. Further, there are grounds within the judicial review application which would not be capable of being covered in the proposed appeal/complaint.

40. I therefore reject the submission that there is an equivalently efficacious alternative remedy available in this case.

41. Accordingly, I set aside all three of the impugned decisions. The appeal decision of 14 January 2020 is set aside because it is a derivation of the first two decisions which are procedurally flawed, as I have explained.

42. The assessment will therefore need to be re-done. In order to avoid any appearance of bias there will need to be a fresh assessor nurse and a fresh panel.

43. In the light of my primary decision it is not necessary for me to deal with issues (iii) and (iv). Plainly, the non-statutory guidance in the Framework should generally be followed as this promotes transparency and consistency in decision-making. However, given that the guidance has not been promulgated by Parliament through the democratic process there must be considerable latitude afforded to individual CCGs as to how they implement it. I cannot accept that the primary decision on 27 November 2019 is additionally to be impugned because of a supposed failure to comply with the terms of the Framework. The decision on 19 December 2019 was devoid of any proper reasoning and is set aside on traditional Wednesbury grounds.

44. I turn to issues (v) and (vi).

45. So far as issue (v) is concerned the relief sought by JP is that a mandatory order should be granted (i.e. an injunction) requiring the local authority promptly to conduct a reassessment of JP's entitlement to care/support pursuant to section 17 of the Children Act 1989 and an assessment of his parents in their capacity as carers pursuant to section 17ZD of that Act. In fact, the local authority has agreed to conduct these assessments although there is a dispute as to the legal scope of care/support that could, in theory at any rate, be provided.

46. Mr Armitage advanced an adventurous argument that section 1 of the Localism Act 2011 empowers the local authority to provide medical care which is clearly within the remit of the NHS and/or the CCG. Section 1(1) provides that "a local authority has power to do anything that individuals generally may do." Therefore, he argues that because an individual can pay for private healthcare for his child, or for that matter somebody else's child, so as a matter of literal construction the local authority could pay for seven-night care of JP even if the CCG lawfully declined to do so.

47. Ms Cooper argues that section 2 of the 2011 Act clearly defines the boundaries in this case. Section 2(2)(a) provides that the general power does not enable the local authority to do anything which the authority is unable to do by virtue of a pre-commencement limitation. A pre-commencement limitation means a prohibition restriction or other limitation expressly imposed by an earlier statutory provision in an Act or statutory instrument. She argues that section 75 of the National Health Service Act 2006 and the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (SI 2000 No.617) clearly delineates the boundaries between the

NHS and local authorities as to what can be provided by whom. This is a limitation expressly imposed.

48. I agree with Ms Cooper. In this context the 2011 Act must be construed purposively and having regard to the supposed intention of its framers. It is inconceivable that its framers could have dreamed that section 1 could be used to usurp decisions reposed in the NHS and its bodies. I cannot accept that the 2011 Act should be construed as driving a coach and horses through very carefully delineated frontiers of competence and function between the NHS on the one hand and local authorities on the other.

49. Finally, I turn to issue (vi). The relief that is sought in this regard is a mandatory order (i.e. an injunction) requiring the defendants to cooperate with one another in conducting the fresh assessments. I have not been shown any authority where an order has been made requiring two public bodies to cooperate with each other.

50. The argument rests on section 10(1) of the Children Act 2004 and section 82 of the National Health Service Act 2006.

    i) The former states "each local authority in England must make arrangements to promote cooperation between… the authority and each of the authority's relevant partners." The relevant partners include any clinical commissioning group for an area any part of which falls within the area of the authority. Section 10(3) provides that in making such arrangements a local authority must have regard to the importance of parents and other persons caring for children in improving the well-being of children.

    ii) The latter states that in exercising their respective functions NHS bodies (on the one hand) and local authorities (on the other) must co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.

51. These are macro or target duties. I am extremely doubtful whether they confer any right on an individual to sue for alleged breach of the provisions. Put another way, I am doubtful that these provisions confer a justiciable right on an individual.

52. If I am wrong, then it is trite law that where there is a right there must be a remedy (*Ashby v White* (1702) 2 Raym. Ld. 938, 92 Eng. Rep. 126; *Marbury v Madison* (1803) 5 U.S. (1 Cranch) 137). But I struggle to conceive of any circumstances where the remedy would extend to the award of an injunction to cooperate.

53. In any event on the facts of this case I am not remotely satisfied that there has been a failure of the duty to cooperate between the local authority and the CCG. True, the local authority has been careful to observe the frontier between its competencies and those of the CCG. But to construe from that a failure to cooperate is in my judgment far-fetched.

54. In my judgment the claims in issues (v) and (vi) are misconceived and must be dismissed.

55. That is my judgment.